(X3) DATE SURVEY

Office of Inspector General STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:	COMPLETED	
		101018	B. WING		C 09/04/2015
	ROVIDER OR SUPPLIER	300 SHE	DDRESS, CITY, STATE BY STATION DRIV LE, KY 40245		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
N 000	INITIAL COMMENTS		N 000		
	concluded on 09/04/1 KY23794. The Divisio	vas initiated on 09/03/15 and 5 to investigate complaint on of Health Care gation with deficiencies			
N 144	902 KAR 20:300-6(7) Life	(b)2.a. Section 6. Quality of	N 144		
	2. The facility shall es program which:	nd communicable diseases. tablish an infection control ols and prevents infections			
	Based on observation and review of the facility determined the facility with a suspected comisolation precautions it test results were deteresults were obtained appropriate personal addition, a resident will disease and in contact have a visitor not weat personal protective edition.	railed to ensure a resident municable disease had in place until the disease rmined and after positive staff and visitors used the protective equipment. In ith a known communicable it isolation was observed to uring the appropriate quipment while in the o (2) of five (5) sampled			
	The findings include:				
	Review of the facility's	s policy regarding Initiating			

(X2) MULTIPLE CONSTRUCTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

09/21/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
			A. BOILDING.		_	,
		101018	B. WING		09/0)4/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
OAKLAWI	N HEALTH & REHABILITA	ATION CENTER	BY STATION DE .E, KY 40245	RIVE		
04015	CHMMADV CT		1	DROVIDED'S DI ANI OF CORRECTION		0.5
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
N 144	Continued From page	± 1	N 144			
	revealed Transmissio be initiated when ther that a resident had a disease. Transmissio	Precautions, not dated, on-Based Precautions would be was a reason to believe communicable infectious n-Based Precautions may autions, Droplet Precautions, ns.				
	for Transmission-Bas revealed in addition to facility would implement residents known or succionized with microtransmitted by direct or indirect contact with to or resident-care items requiring Contact Preassociated with Clost Contact Precautions, wound infections coloresistant organisms, so Staphylococcus Aurestrain of bacteria which the antibiotics common staph infections). Which contact precautions, gentering the resident's worn for all interaction with the resident or poitems in the resident's would also ensure the	such as Methicillin-resistant us (an infection caused by a ch has become resistant to only used to treat ordinary ile caring for residents in gloves would be worn upon s room and gowns would be ns that may involve contact otentially contaminated s environment. The facility				
	09/03/15 at 9:17 AM, resident's stay at the	ident #1' family member, on revealed that during the facility Resident #1 and the physician ordered				

Office of	Inspector General					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		101018	B. WING		C 09/04/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE. ZIP CODE		
		300 SHI	ELBY STATION DI			
OAKLAWI	N HEALTH & REHABILIT	ATION CENTER	/ILLE, KY 40245			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE	
N 144	Continued From page 2		N 144			
	(C-diff.). The family mordered on 08/17/15; obtain the stool for tephysician inquired abmember had assume completed and the faresults; not that the tecompleted. He/she scollected, the results family member stated ordered stool test unt Resident #1 was not precautions and his/r Resident #1. He/She of the grandchildren. even after the facility isolation precautions,	stated once the stool was were positive for C- diff. The d from the time of the till confirmation of C-diff; placed in isolation her grandchildren visited had concerns for the health The family member stated placed Resident #1 in , staff did not adhere to ate personal protective				
	revealed the facility a 07/03/15 with diagnoun fection, Diabetes, a Failure. The facility di 07/30/15. Review of I Minimum Data Set (Not completed on 07/10/1 for Mental Status (BII and the facility asses of fourteen (14) mean interviewable.	and Congestive Heart ischarged the resident on Resident #1's Annual MDS) assessment, 15, revealed a Brief Interview MS) exam was conducted sed the resident with a score ning the resident was ian Orders, dated 07/13/15, in ordered a stool study with if the resident had				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		101018		B. WING		C 09/04/2015
NAME OF D		101010	CTDEET ADDE	DECC CITY CTA	TE 7/D 00DE	1 03/04/2010
NAME OF PI	ROVIDER OR SUPPLIER			RESS, CITY, STA		
OAKLAWI	N HEALTH & REHABILITA	ATION CENTER	LOUISVILLE	Y STATION DE	RIVE	
04.0.45	CHMMADV CT		LOGIOVILLE	•	DDOMDEDIS DI AN OF CODDECT	ON
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIC		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
N 144	Continued From page	2 3		N 144		
	results, dated 07/24/1	n. Review of the laborato 5, revealed Resident #1 estridium Difficile eleven vas obtained.	ı			
	placed in isolation if disease. The Unit Ma would be placed on the precautions and the aprotective equipment door for staff and visit staff and visitors should be approximately as the control of the co	revealed residents woul liagnosed with a contagi nager #1 stated a sign ne door noting isolation	e the red			
	09/04/15 at 2:58 PM, responsible for the Interpretation obtaining the ordered test for Clostridium Discrete member had not said infection control pract would not put a reside for a case of suspecte (C-diff.), even though resident's would be puspected case of C-put Resident #1 in isoprecautions, until after test result, confirming DON stated nursing mesponsible for monitor prevention intervention DON did not provide oprevention activities of	fection Control Program d she had received a ent #1's family regarding stool specimen timely to ifficile. However, the fam anything about not follocices. She stated the facent into contact precautions de Clostridium Difficile the facility policy stated laced in precautions for diff. She stated they didulation with contact or they received the position the resident had C-diff. In an agement was pring and ensuring infections were implemented.	in g not o nily wing ility ons a not tive The tion The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		101018	B. WING		C 09/04/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	·
OVKLVM	N HEALTH & REHABILITA	ATION CENTER 300 SH	ELBY STATION DRIV	/E	
OARLAWI	THEALTH & KEHABILIT	LOUIS	/ILLE, KY 40245		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	CTION SHOULD BE COMPLETE O THE APPROPRIATE DATE
N 144	Continued From page	e 4	N 144		
	protective equipment.				
	08/30/15 with diagnost Vulva, Methicillin-residureus (an infection of bacteria which has be antibiotics commonly infections) of the right Review of Resident # completed on 09/04/1 for Mental Status (BIM and the facility assess of fifteen (15) meaning interviewable.	dmitted the resident on ses of Sepsis, Cancer of the stant Staphylococcus caused by a strain of ecome resistant to the used to treat ordinary staph tower extremity and elbow. 5's Social Services note, 5, revealed a Brief Interview MS) exam was conducted sed the resident with a score			
	#5's room, revealed a Precautions was on tl Continued observatio seated on a couch an	in isolation sign for Contact ne wall outside the room. n revealed a visitor was d was not wearing the d gloves required for contact			
	PM, revealed not all sto the isolation precautappropriate personal while in his/her room. visitor that came on 0 not be infected with M touch him/her. The renot aware that MRSA others after touching touched and had not Interview with Certifie	protective equipment (PPE), Resident #5 stated the 9/03/15, believed they could IRSA as long as they did not sident stated he/she was could be contracted by surfaces he/she had			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SI COMPLE	
			71. 201221110.		c	
		101018	B. WING		1	4/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
OAKLAWI	N HEALTH & REHABILITA	ATION CENTER	BY STATION DF .E, KY 40245	RIVE		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	y T	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETE DATE
N 144	Continued From page	9 5	N 144			
	stated the resident was the wound and all state the appropriate PPE pHe stated he did not president #5's room whe stated wearing the of the infection. Interview with License 09/03/15 at 2:57 PM, MRSA of the wound a Precautions to prever She stated all staff an appropriate personal prior to entering the reaware the resident has was not wearing the ait was important for evisolation precautions.	without the appropriate PPE. e PPE prevented the spread ed Practical Nurse #1, on revealed Resident #5 had and was on Contact nt the spread of the disease. nd visitors should wear the protective equipment (PPE) oom. However, was not ad a visitor in the room who appropriate PPE. She stated veryone to follow Contact to prevent the spread of the responsibility of staff to				
	09/04/15 at 2:58 PM, should follow the Conrequirements to preve for Resident #5. How Resident #5 had a visappropriate PPE. Sh responsibility of staff Isolation precautions Interview with the Interview w	to ensure the Contact were followed. erim Administrator, on revealed she was not aware e not adhering to Contact ents to prevent the spread of				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
ANDILAN	" CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		
		101018	B. WING		C 09/04/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
OAKLAWI	N HEALTH & REHABILITA	ATION CENTER	BY STATION DI	RIVE	
		LOUISVILL	E, KY 40245		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
N 144	Continued From page	Continued From page 6			
	the facility management to ensure infection prevention policies were followed.				
N 185	902 KAR 20:300-7(2) Assessment	(e) Section 7. Resident	N 185		
	to develop, review, ar	ssessments. of the assessment are used nd revise the resident's of care, under subsection (4)			
	This requirement is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to develop a care plan with interventions to care for a resident with Clostridium Difficile (a bacterium that causes diarrhea and more serious intestinal conditions) for one (1) of five (5) sampled residents. (Resident #1)				
	The findings include:				
	The facility did not prodevelopment of reside	ovide a policy regarding the ent's care plans.			
	(RAI), Minimum Data 4-8, revealed the facil assessing and addres relevant to the individ whether or not they a including monitoring of responding with appro 4-12 revealed the ove oriented towards: pre	ent Assessment Instrument Set (MDS), Chapter 4, page lity was responsible for ssing all care issues that are lual residents, regardless of re covered by the RAI, each resident's condition and opriate interventions. Page erall care plan should be eventing avoidable declines; s; addressing resident's			

	TEICATION NI IMBED:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION IDEN	TIFICATION NUMBER.	A. BUILDING: _			
10	1018	B. WING		C 09/04/2015	
NAME OF PROVIDER OR SUPPLIER		RESS, CITY, STA			
OAKLAWN HEALTH & REHABILITATION CE	NTER	BY STATION DF .E, KY 40245	RIVE		
(X4) ID SUMMARY STATEMENT O PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTIF	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
strength; evaluating treatments additional care planning areas meeting the resident's needs. Review of the facility's policy or Transmission Based Precaution revealed Transmission-Based be initiated when there was an that a resident had a communidisease. Transmission-Based include Contact Precautions, for Airborne Precautions. Review of the facility's policy or for Transmission-Based Precautions. Review of the facility's policy or for Transmission-Based Precautions are identify would implement Contact residents known or suspected colonedzed with micro-organist transmitted by direct contact windirect contact with the enviro or resident-care items. Example requiring Contact Precautions associated with Clostridium Diwould also ensure that the resindicated the type of precaution the resident. Review of Resident #1's closed revealed the facility admitted the 107/03/15 with diagnoses of Uril Infection, Diabetes, and Congeled Failure. The facility discharged 107/30/15. Review of Resident #1's Annual Set (MDS) assessment, complemental assessed the resident with a sessessed	egarding Initiating ons, not dated, Precautions would reason to believe icable infectious Precautions may Droplet Precautions, undated, rd Precautions, the fact Precautions for to be infected or sms that could be with the resident or inmental surfaces les of infections included Diarrhea officile. The facility idents care plan ins implemented for definitional record the resident on inary Tract the Resident #1 on all Minimum Data letted on 07/10/15, Mental Status and the facility	N 185			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		101018	B. WING		C 09/04/2	015	
NAME OF P	ROVIDER OR SUPPLIER		REET ADDRESS, CITY, STA				
OAKLAWI	N HEALTH & REHABILIT	ATION CENTER	O SHELBY STATION D UISVILLE, KY 40245	RIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETE DATE	
N 185	Review of Physician or revealed Resident #1 physician ordered a state determine if the resident Review of Laboratory revealed Resident #1 Clostridium Difficile. Review of the Compronent Resident #1, revealed developed at the time after the facility receiv #1 had the infectious Difficile. Interview with Unit Maye:10 AM, revealed aft physician's order she resident's care plan winterventions related to Manager stated she cat that time she receiv Resident #1's stool for Clostridium Difficile. Serelated to infection conshould have been developed at 2:58 PM, complaint from Residio obtaining the ordered not about staff not us protective equipement.	Orders, dated 07/13/15, had diarrhea and the tool study with cultures to ent had Clostridium Difficile results, dated 07/24/15, tested positive for ehensive Care Plan for a plan of care was not the physician suspected of the physician suspected of the confirmation, Resident disease, Clostridium anager #1, on 09/04/15 at er a nurse received a should update the with the appropriate to the order. The Unit did not update the care plan yed the order to collect or the contagious disease of the stated a care plan introl of Clostridium Difficile yeloped in order for staff to the resident.	r f				
	had not developed a	olan of care related to the on or after the confirmed					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		101018	B. WING		C 09/04/2015
	ROVIDER OR SUPPLIER	300 SHEL	DRESS, CITY, STA BY STATION DI LE, KY 40245		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 185	care plan should have	um Difficile. She stated a e been developed related to ices in order for staff to	N 185		
	at 4:25 PM, revealed Resident #1's family's lack of timeliness in c However, she had no did not have a care pl order for stool collecti results were received facility still had educar related to the complai should have developed #1 in order to provide	Administrator, on 09/04/15 she had been informed of a complaint regarding the ollecting the stool specimen. It been told that Resident #1 an developed after the on or the positive test. She stated obviously the tion and training to complete int. She stated nursing a care plan for Resident the necessary care and the spread of the infection.			
N 194	Assessment (4) Comprehensive ca (c) The services provifacility shall: 2. Be provided by qua	ded or arranged by the	N 194		
	Based on observation and review of the facility determined the facility care plans related to so occult blood and infect	not met as evidenced by: n, interview, record review lity's policy, it was not failed to follow resident specimen collection for ection control practices for appled residents. (Resident's			

` ,		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	TED
					С	
		101018	B. WING		09/04	/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
OAKI AWI	N HEALTH & REHABILITA	ATION CENTER 300 SHELF	BY STATION DE	RIVE		
OARLANI	THEACHT & REHABIETT	LOUISVILL	LE, KY 40245			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 194	Continued From page	e 10	N 194			
	The findings include:					
	The facility did not profollowing the resident collection of specimen	•				
	(RAI), Minimum Data 4-10 revealed key tas process is monitoring towards goals and mo needed. The key task process included: ide response to interventi	ntify the individual's ions and treatments; identify				
	goals; define or refine interventions, review consequences related interventions as need objectives have been	ress towards achieving when to stop or modifiy effectiveness and adverse d to treatments; adjust ded; and, identify when care achieved sufficiently to ransfer, or change in level of				
	-	ndicated the type of				
	08/11/15 with diagnos	nt #3's clinical record Idmitted the resident on ses of Perpherial Vascular ure, and Atrial Fibrillation.				
	Set (MDS) assessme revealed a Brief Interv (BIMS) exam was cor assessed the residen	t3's Annual Minimum Data ent, completed on 0/8/18/15, view for Mental Status nducted and the facility at with a score of thirteen ident was interviewable.				

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		101018	B. WING		C 09/04/2015	
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
OAKLAWI	N HEALTH & REHABILITA	ATION CENTER	BY STATION DI LE, KY 40245	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	
N 194	4 Continued From page 11		N 194			
	Resident #3 revealed 08/24/15 with updated 08/24/15. The proble risk for complications therapy. The goal sta have active bleeding, the staff to observe foi.e., nose bleeds, blees stool. Observation, on 09/03. Resident #3 was in be resident appeared cleight and fluids in reacon, 09/04/15 at 11:25 for occult blood was considered.	rehensive Care Plan for a plan was developed on d goals and a target date for em stated the resident was at related to anticoagulation at the test of the resident would not a signs of active bleeding reding gums, blood in urine or a signs of active bleeding reding gums, blood in urine or a signs of active bleeding reding gums, blood in urine or a signs of active bleeding reding gums, blood in urine or a signs of active bleeding reding gums, blood in urine or a signs of active bleeding reding gums, blood in urine or a signs of active bleeding reding gums, blood in urine or a signs of active bleeding reding gums, blood in urine or a signs of active bleeding reding gums, blood in urine or a signs of active bleeding reding gums, blood in urine or a signs of active bleeding reding gums, blood in urine or a signs of active bleeding gums, blood in urine or a signs of				
	revealed the physicia	Orders, dated 08/17/15, in ordered Resident #3's o (2) times for occult blood.				
	Practical Nurse #2 reintervention for Resid observe for signs and Resident #3's stool. Sordered test would be bleeding in the stool.	lent #3 required nursing to d symptoms of bleeding in She stated completing the e one way to observe for She stated as of, 09/03/15, completed and did not				
	3:30 PM, revealed his nursing interventions Resident #3 had a ca	anager #1, on 09/03/15 at s responsibility was to ensure were followed. He stated are plan intervention to blood. He stated he was not				

STATEMENT OF DEFIC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPLI	
			_			<u> </u>
		101018	B. WING		1	4/2015
NAME OF PROVIDER O	R SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
OAKLAWN HEALTI	1 & REHABILIT	ATION CENTER	BY STATION DI	RIVE		
		LOUISVILL	.E, KY 40245			
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
N 194 Continu	ued From page	e 12	N 194			
aware to blood in comple copies each shour transcripensure. He statt if nursire intervers. Intervier on 09/04/11 sevente nursing. She state should breakded intervier on 09/04/11 Reside monitor.	the physician of Resident #3's ted timely. He of the physician iff to ensure the bed to the appropriate the resident and the resident of the resident of the resident of the stated of the specimen shall be specimen to be followed arown in the property with the Direct States of the specimen shall be specimen shall be specimen to the specimen shall be spe	ordered test, to monitor for s stool, had not been stated he reviewed the an orders at the beginning of hey had been faxed and propriate location, but did not implemented the intervention. It could have a bad outcome dement care plan sistant Director of Nursing, PM, revealed one of Resident entions required nursing to symptoms of bleeding in the collection and testing of mould have been done as in receiving the order on she was not aware past, and the ordered had not been implemented. For each of Nursing, on revealed she was not aware an intervention for lood had not been incomplemented and intervention for lood had not been incomplemented.	N 194			
monitor	ing to make s	ated nursing should be ure the intervention had				
the pro- She sta was im stated i implem could o	cess, but was ated implemen portant for the f care plan into ented a negat ccur.	nd there was a breakdown in not sure how it happened. ting care plan interventions care of the resident. She erventions were not ive outcome for the resident				

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUR COMPLETE	
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		101018	B. WING		C 09/04/2	2015
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OAKLAWI	N HEALTH & REHABILIT	ATION CENTER	BY STATION DI	RIVE		
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N 194	Continued From page	e 13	N 194			
	08/30/15 with diagnost Vulva, Methicillin-resi Aureus (an infection obacteria which has be antibiotics commonly infections) of the right Review of Resident # completed on 09/04/1 for Mental Status (BIT)	ecome resistant to the used to treat ordinary staph t lower extremity and elbow. 5's Social Services note, 15, revealed a Brief Interview MS) exam was conducted sed the resident with a score				
	isolation sign for Con wall outside Resident observation of Reside visitor was seated on	3/15 at 2:52 PM, revealed an tact Precautions was on the t #5's room. Continued ent #5's room revealed a a couch and did not have own and gloves needed for				
	PM, revealed not all sto the isolation precata appropriate personal while in his/her room. visitor that came on 0 not be infected with N touch him/her. The renot aware that MRSA others after touching touched and had not Review of the Compr. Resident #5 revealed.	protective equipment (PPE), Resident #5 stated the 09/03/15 believed they could MRSA as long as they did not esident stated he/she was a could be contracted by surfaces he/she had been cleaned. Tehensive Care Plan for If a plan was developed on				
	09/04/15. The proble	d goals and a target date for em stated the resident had staphylococcus aureus				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		101018	B. WING		C 09/04/20	015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
OAKLAWI	N HEALTH & REHABILIT	ATION CENTER	BY STATION DI .E, KY 40245	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE C	(X5) OMPLETE DATE
N 194	Continued From page	e 14	N 194			
	stated. The approach maintain Contact isola right lower extremity a ordered.	an did not have a goal es directed the staff to ation for possible MRSA of and to provide treatment as				
	#1, on 09/03/15, at 3: assigned to provide of stated the resident was the wound and all state the appropriate PPE he did not know there #5's room without the	d Nursing Assistant (CNA) 13 PM, revealed he was are to Resident #5. CNA #1 as in isolation for MRSA of ff and visitors were to wear while in the room. He stated was a visitor in Resident appropriate PPE. He stated part of the plan of care for				
	09/03/15 at 2:57 PM, MRSA of the wound a Precautions to prever She stated all staff ar appropriate personal prior to entering the raware the resident hawearing the appropriaresident's plan of care should be followed by responsibility of staff. Interview with the Direction of the Correquirments to prever Resident #5. However	nt the spread of the disease. Ind visitors should wear the protective equipment (PPE) Doom. However, was not and a visitor in the room not after PPE. She stated the perfor Contact isolation				
	She stated it was the	responsibility of staff to interventions were followed.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		101018	B. WING			C 04/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
OAKI AWI	N HEALTH & REHABILITA	ATION CENTER 300 SH	ELBY STATION DRI	VE		
OARLANI	TIEREIT & REHABIETT	LOUIS	/ILLE, KY 40245			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
N 199	Continued From page	e 15	N 199			
N 199	902 KAR 20:300-8 Se	ection 8. Quality of Care	N 199			
	attain and maintain the and physical functions comprehensive assess Each resident shall refacility must provide the services to attain or in practicable physical, it	psychosocial services to the highest possible mental al status, as defined by the essment and plan of care. The services and the the necessary care and the national the highest mental, and psychosocial ance with the comprehensive				
	Based on observation and review of the faci determined the facility staff followed physicial specimen collection at Difficile and occult blo	failed to ensure nursing				
	The findings include:					
		ovide a policy or procedure nysician orders or specimen				
	revealed the facility a 07/03/15 with diagnost Infection, Diabetes, a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		C
		101018	B. WING		09/04/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
OAKLAWI	N HEALTH & REHABILIT	ATION CENTER	BY STATION DI LE, KY 40245	RIVE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
N 199	for Mental Status (BII and the facility assess of fourteen (14) mean interviewable. Review of the Compression Resident #3 revealed 08/24/15 with update 08/24/15. The proble risk for complications therapy. The goal state have active bleeding. The staff to observe for i.e., nose bleeds, bleed stool. Review of the Physical revealed Resident #1 physician ordered as determine if the resident Review of the Laborate revealed Resident #1 Clostridium Difficile. On 09/04/15 at 9:10 / Manager (UM) #1 revealed Resident #1 soon as possible. Shof the ten day delay in specimen until the fair results. The Unit Manknow where the breat process to collect Resident Res	Resident #1's Annual MDS) assessment, 15, revealed a Brief Interview MS) exam was conducted sed the resident with a score ning the resident was rehensive Care Plan for a plan was developed on a goals and a target date for em stated the resident was at a related to anticoagulation at the test and the approaches directed or signs of active bleeding reding gums, blood in urine or a signs of active bleeding reding gums, blood in urine or a signs of active bleeding reding gums, blood in urine or a signs of active bleeding reding gums, blood in urine or a signs of active bleeding reding gums, blood in urine or a sign o	N 199		
		failed to communicate from specimen had not been			

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		101018	B. WING		C 09/04/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE, ZIP CODE	
O A IZI AVAII	LUCALTU O DELLADULT	ATION CENTER 300 SHELI	BY STATION DE	RIVE	
UAKLAWI	N HEALTH & REHABILIT	LOUISVILI	E, KY 40245		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
N 199	Continued From page	e 17	N 199		
	orders daily to ensure laboratory and pharm they were completed. Interview with the Dir 09/04/15 at 2:58 PM, complaint from Resid obtaining the ordered	ector of Nursing (DON), on revealed she received a ent #1's family regarding not stool specimen and test			
	results timely. The DON stated nursing should implement physician orders as soon as possible after receiving the order. She stated she believed the nursing staff had a shift to shift				
	communication proble addressed this issue	em; however, had not as of yet.			
	Interview with Interim at 4:25 PM, revealed Resident #1's family's lack of timeliness in of The Interim Administr complaint was address were put in place to pfrom occurring again; this surveyor found a 08/17/15, for another implemented until sur stated obviously the fitraining to complete riphysician orders. She follow and implemented	Administrator, on 09/04/15 she had been informed of a complaint regarding the ollecting a stool specimen. Fator stated the family's seed and believed actions arevent this type of issue however, was not aware physician order, dated resident that had not been except intervention. She facility still had education and elated to the following of the stated nursing should physician orders timely or tially experience a negative			
	08/11/15 with diagnost Disease, Kidney Failu Review of Resident #	t #3's clinical record dmitted the resident on ses of Periphera Vascular ure, and Atrial Fibrillation. 3's Annual Minimum Data nt, completed on 0/8/18/15,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	(X3) DATE SURVEY COMPLETED	
		101018	B. WING		C 09/04/2015
NAME OF D			DDDECC CITY CTAT	F. 71D CODE	1 00/04/2010
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT		
OAKLAWI	N HEALTH & REHABILITA	ATION CENTER	LBY STATION DR ILLE, KY 40245	IVE	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETE THE APPROPRIATE DATE
N 199	Continued From page	e 18	N 199		
	(BIMS) exam was cor assessed the residen	view for Mental Status nducted and the facility t with a score of thirteen dent was interviewable.			
	Resident #3 revealed 08/24/15 with updated 08/24/15. The proble risk for complications therapy. The goal star have active bleeding, the staff to observe for	ehensive Care Plan for a plan was developed on d goals and a target date for m stated the resident was at related to anticoagulation ted the resident would not The approaches directed or signs of active bleeding eding gums, blood in urine or			
	Resident #3 was in be resident appeared cle light and fluids in reac resident on, 09/04/15 specimen for occult b	at 11:25 PM, revealed a lood was collected on dent did not know when the			
	revealed the physicial stool to be tested two On 09/03/15 at 1:05 F Licensed Practical Nunursing intervention for nursing to observe for bleeding in Resident stompleting the ordere observe for bleeding in	Orders, dated 08/17/15, n ordered Resident #3's (2) times for occult blood. PM, an interview with arse (LPN) #2 revealed a per Resident #3 required a per Resident #3 required a symptoms of #3's stool. LPN #2 stated and test would be one way to in the stool. She stated all be implemented as soon			
	as possible after rece 09/03/15, the test had did not know the reas	not been completed and			

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
7.11.2 . 2.11.			A. BUILDING: _			
		101018	B. WING		09/0) 14/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	,1 3333	
0.41/1.414/1	LUCALTU O DELLA DILIT	300 SHELE	BY STATION DI	RIVE		
OAKLAWI	N HEALTH & REHABILIT	LOUISVILI LOUISVILI	E, KY 40245			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
N 199	Continued From page	e 19	N 199			
	Interview with Unit Mat 1:05 PM, revealed ensure nursing interv#1 stated Resident #intervention to monitor stated he was not aw test, to monitor for blohad not been comple reviewed the copies of beginning of each shiftaxed and transcribed but did not ensure nurintervention. He state	anager (UM) #1, on 09/03/15 his responsibility was to entions were followed. UM				
	on 09/03/15 at 1:15 F and testing of Reside been done as soon a order on 08/17/15. St seventeen days had nursing intervention h She stated physician timely and was not so the process occurred. Interview with the Dir 09/04/15 at 2:58 PM, Resident #3's physici occult blood had not stated nursing should orders immediately a stated she was not so the process occurred communication issue	nad not been implemented. orders should be followed ure where the breakdown in . ector of Nursing, on revealed she was not aware ian order to test stool for been implemented. She if be implementing physician fter receiving them. She ure where the breakdown in , but believed the staff had a . She stated if physician emented the resident could				

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:					
		101018	B. WING		1	4/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE, ZIP CODE		
OAKLAW	N HEALTH & REHABILIT	TATION CENTER	BY STATION DI LE, KY 40245	RIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
N 199	Continued From pag	e 20	N 199			
	On 09/04/15 at 4:25 Administrator reveale Resident #3's occult 08/17/15, had not be was responsible for e were implemented as stated obviously the education on the imp	PM, an interview with Interimed she was not aware blood stool test, ordered on en done. She stated nursing ensuring physician orders a soon as possible. She staff needed re-training and				